GPs In At The Deep End – Supporting Scotland's Families. Rights, Respect, Relationships.

GPs at the Deep End

UNITED NATIONS

CRC

Convention on the Rights of the Child

Distr.
GENERAL

CRC/C/GC/7/Rev.1
20 September 2006

Original: ENGLISH

COMMITTEE ON THE RIGHTS OF THE CHILD
Fortieth Session
Geneva, 12-30 September 2005

GENERAL COMMENT No. 7 (2005)

Implementing child rights in early childhood

I. INTRODUCTION

1. This general comment arises out of the Committee's experiences of reviewing States parties' reports. In many cases, very little information has been offered about early childhood, with comments limited mainly to child mortality, birth registration and health care. The Committee felt the need for a discussion on the broader implications of the Convention on the Rights of the Child for young children. Accordingly, in 2004, the Committee devoted its day of general discussion to the theme "Implementing child rights in early childhood". This resulted in a set of recommendations (see CRC/C/143, sect. VII) as well as the decision to prepare a general comment on this important topic. Through this general comment, the Committee wishes to encourage recognition that young children are holders of all rights enshrined in the Convention and that early childhood is a critical period for the realization of these rights. The Committee's working definition of "early childhood" is all young children: at birth and throughout infancy; during the preschool years; as well as during the transition to school (see paragraph 4 below).

II. OBJECTIVES OF THE GENERAL COMMENT

2. The objectives of the general comment are:

- To encourage recognition of young children as social actors from the beginning of life, with particular interests, capacities and vulnerabilities, and of requirements for protection, guidance and support in the exercise of their rights;
- To emphasize the vulnerability of young children to poverty, discrimination, family breakdown and multiple other adversities that violate their rights and undermine their well-being;
- To contribute to the realization of rights for all young children through formulation and promotion of comprehensive policies, laws, programmes, practices, professional training and research specifically focused on rights in early childhood.

CHILDREN'S HUMAN RIGHTS ARE BEING INCREASINGLY EMBEDDED INTO EU LEGISLATION AND POLICY. THIS IS HELPING TO ENSURE THAT CHILDREN'S HUMAN RIGHTS ARE PROTECTED, RESPECTED AND FULFILLED ACROSS THE EU IN LINE WITH THE CHARTER OF FUNDAMENTAL RIGHTS.

The State Discovers Child Welfare- History Matters

- **The 19th century was regarded as an important period of welfare reform** whose philosophical approach changed from 'rescue, reclamation and reform of children' to the involvement of **children given a new social and political identity as belonging to 'the nation'.**
- **1833** Factory Act, this banned children from working in textile factories under the age of nine. From **nine to thirteen they were limited to nine hours a day and 48 hours a week.**
- **The Poor Law (Amendment Act) 1868 rendered parents liable to punishment** if they neglected to provide food, clothing or medical aid for their children however this responsibility was ignored by many guardians.
- **The 1889 Prevention of Cruelty to Children Act known as the Children's Charter,** was amended and extended to allow children to give evidence in court, **mental cruelty was recognised** and it became an offence to deny a sick child medical attention .

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A GLOBAL AGENDA

Comparing Child-focused Sustainable Development Goals (SDGs) in High-income Countries: Indicator Development and Overview

Dominic Richardson, Zlata Brukauf,
Emilia Toczydlowska, Yekaterina Chzhen

Office of Research - Innocenti Working Paper
WP-2017-08 | June 2017

“health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity’ (WHO)

unicef | for every child

- **NO POVERTY**
- **ZERO HUNGER**
- **GOOD HEALTH AND WELL-BEING**
- **QUALITY EDU-CATION**
- **DECENT WORK AND ECO- NOMIC GROWTH**
- **REDUCED IN-EQUALITIES**
- **SUSTAINABLE CITIES AND COMMUNIITIES**
- **RESPONSIBLE CONSUMPTION AND PRODUCTION**
- **PEACE JUSTICE AND STRONG INSITUTIONS**

Fairness for Children

A league table of inequality in child well-being in rich countries

hbsc

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Child Health- What's It Got to Do With General Practice ?

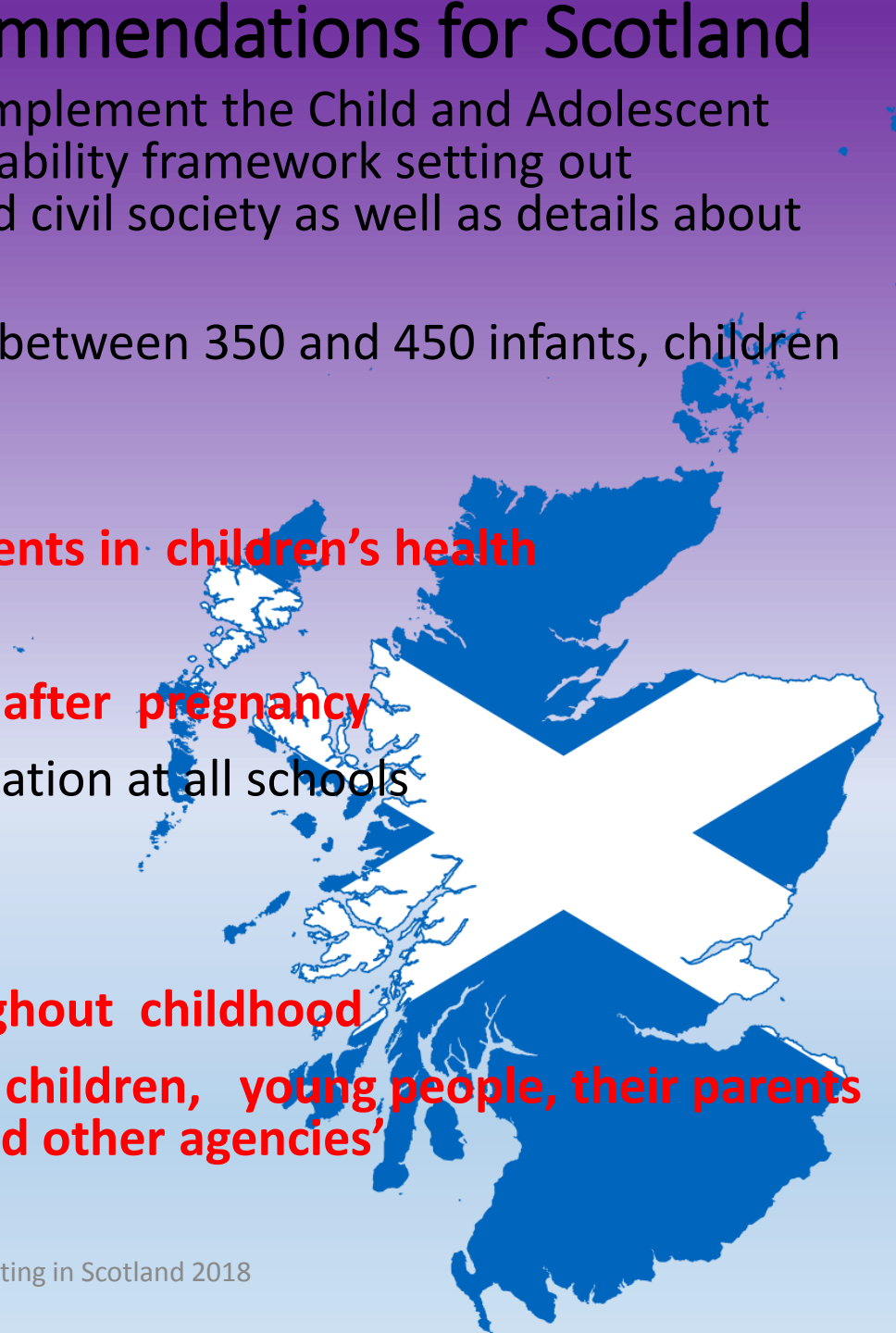
Health Promotion Supporting Parenting Child and Youth Friendly Services Transitional Care Safeguarding Managing Sick Children End of Life Care Disability and Complex Needs Mental Health Medicines and Prescribing

'The RCGP firmly believes that general practice occupies a central position in children and young people's health, particularly in the diagnosis and management of illness and the promotion of health and wellbeing. We are concerned that unless the profession acts now to protect this important and trusted role, it will become eroded and lead to serious fragmentation of care for this vulnerable group of patients'

(RCGP Child Health Strategy 2010-2015)

State of Child Health 2017 –Recommendations for Scotland

1. The Scottish Government should publish and implement the Child and Adolescent Health and Wellbeing Strategy ‘a clear accountability framework setting out responsibilities for professionals, the public and civil society as well as details about resources and funding to implement it’
2. Reduce the number of child deaths (each year between 350 and 450 infants, children and young people die in Scotland)
3. **Develop integrated health and care statistics**
4. **Develop research capacity to drive improvements in children’s health**
5. Reduce child poverty and inequality
6. **Maximise women’s health before, during and after pregnancy**
7. Introduce statutory sex and relationships education at all schools
8. Strengthen tobacco control
9. Tackle childhood obesity effectively
10. **Maximise mental health and wellbeing throughout childhood**
11. **Tailor the health system to meet the needs of children, young people, their parents and carers ‘a joined-up approach by health and other agencies’**
12. **Implementing guidance and standards**



Looking after Families in General Practice- It's In Our DNA

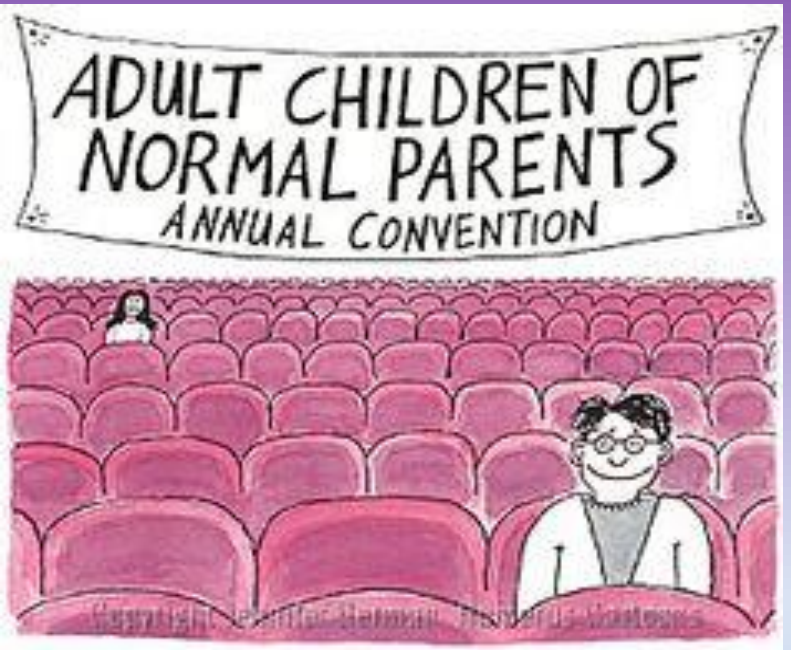
- **The vulnerable child was never far from sight of GPs who in the era of pre-NHS chose to work in impoverished under-doctored areas without the support of a welfare state or unified health service. This was particularly true of the early female GPs who were arguably the Deep End Pioneers of their day.**
- **They built up large lists of women and child patients by 'squatting' in run down premises 'driven by a strong social conscience to practise in a very poor area…Medical women were less hierarchical in their work ;they did things *with* their patients not *to* them' (Anne Digby, The Evolution of British General Practice)**

The Modern Holistic Practitioner

It began as a small clinic in Glasgow, often sneered at for the work it did to help pregnant women with drug, alcohol, HIV and mental health problems. But the system used at Glasgow Women's Reproductive Health Service, set up in 1990, has now helped to model similar services around the world. The guidelines and recommendations used by the clinic, now known as the Special Needs in Pregnancy Service (Snips), are now in place UK-wide and internationally recognised as the correct way to treat socially disadvantaged mothers-to-be

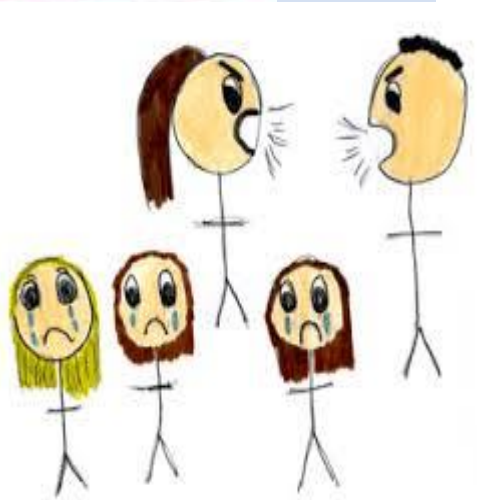
http://www.heraldscotland.com/news/14777840.How_clinic_gave_birth_to_a_maternity_care_model_worldwide/.

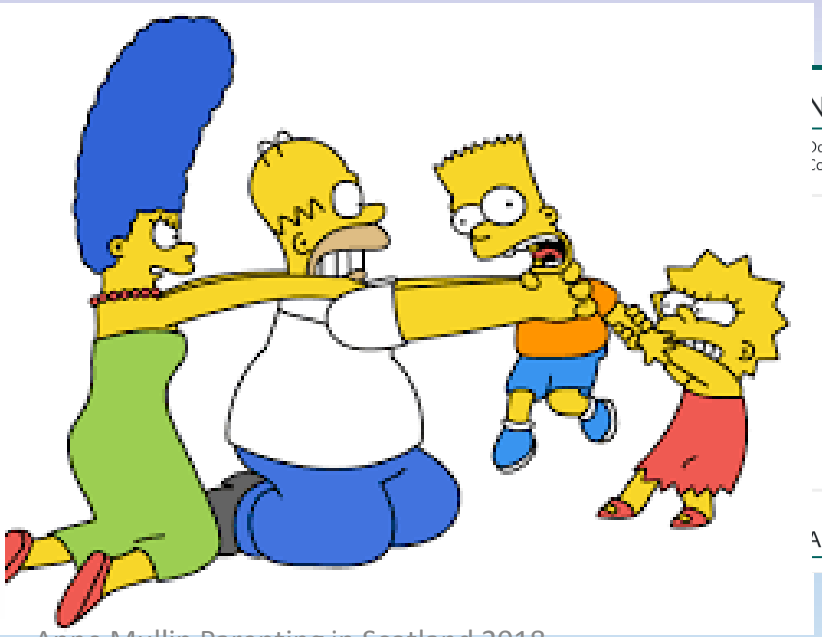
PARENTING BY THE BOOK



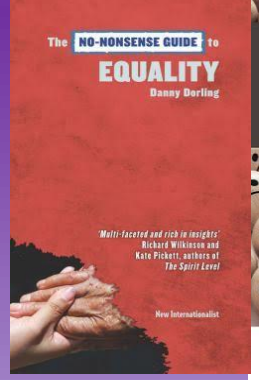
'To be a good enough parent one must be able to feel secure in one's parenthood, and one's relation to one's child...The security of the parent about being a parent will eventually become the source of the child's feeling secure about himself.'

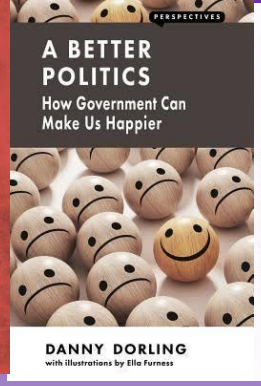
Bruno Bettelheim

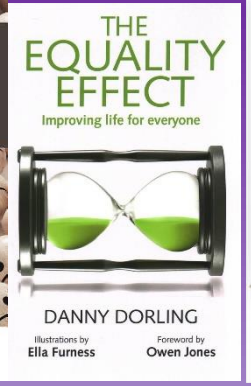


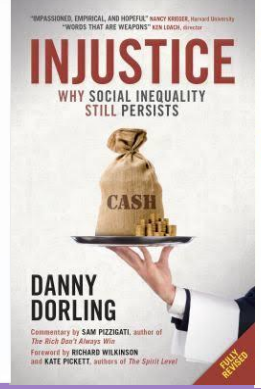


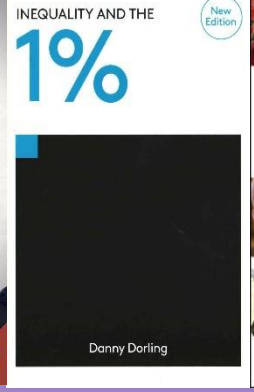
SOCIETY BY THE BOOK

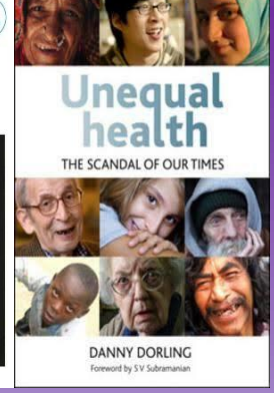












'IN A COUNTRY WHERE THE INCOME AND WEALTH GAPS HAVE BECOME GREATER THAN AT ANY POINT IN LIVING MEMORY, AND WHICH ARE GREATER THAN IN ALMOST ALL OTHER SIMILAR WEALTHY COUNTRIES, YOU SHOULD EXPECT VERY HIGH AND RISING LEVELS OF CRIME, SOCIAL DISORDER, DYSFUNCTION, RISING POLARISATION, FEAR AND ANXIETY'

http://www.dannydorling.org/?page_id=3008

'YOUNG ADULTS IN BOTH BRITAIN AND THE USA TODAY HAVE ONLY EVER KNOWN A COUNTRY IN WHICH INCOME AND WEALTH HAVE BEEN REDISTRIBUTED FROM POOR TO RICH—TO THE DETRIMENT OF ALL. HOW MUCH MONEY COULD BE SAVED BY DOING THE REVERSE AND REDISTRIBUTING FROM RICH TO POOR?'

http://www.dannydorling.org/?page_id=3008

OUR ANALYSIS DEMONSTRATES THAT PERSONS WHO SUFFER HOUSING ARREARS EXPERIENCE INCREASED RISK OF WORSENING SELF-REPORTED HEALTH, ESPECIALLY AMONG THOSE WHO RENT. FUTURE RESEARCH IS NEEDED TO UNDERSTAND THE ROLE OF ALTERNATIVE HOUSING SUPPORT SYSTEMS AND AVAILABLE STRATEGIES FOR PREVENTING THE HEALTH CONSEQUENCES OF HOUSING INSECURITY…THESE ADVERSE ASSOCIATIONS WERE ONLY EVIDENT IN PERSONS BELOW THE 75TH PERCENTILE OF DISPOSABLE INCOME

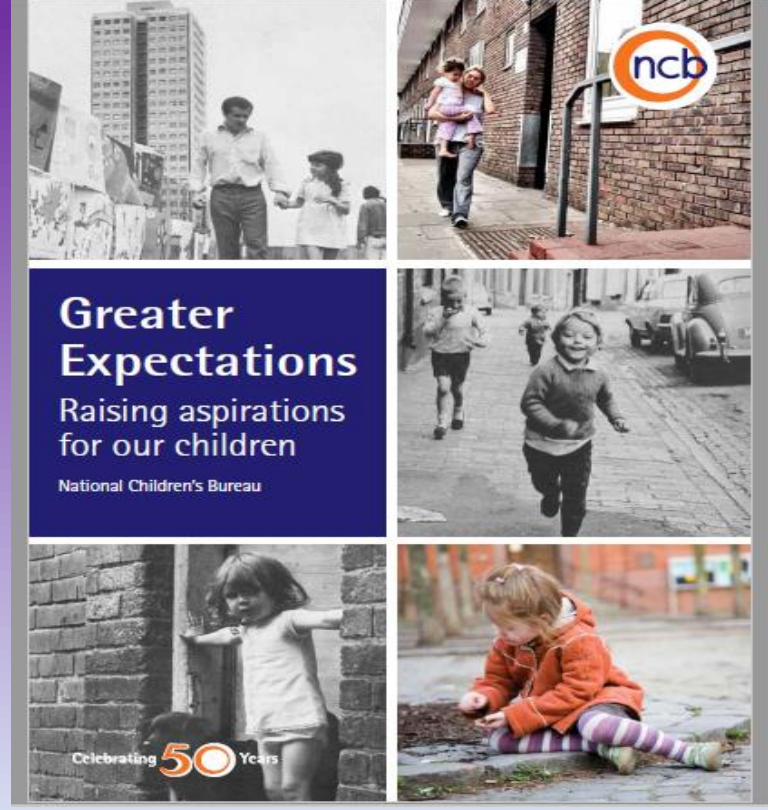
The impact of the housing crisis on self-reported health in Europe: multilevel longitudinal modelling of 27 EU countries. European Journal of Public Health 26(5), 788-793. 1-10-2016

BORN TO FAIL

Are children still experiencing inequality and disadvantage?

Far from improving over time, the situation today appears to be no better than it was nearly five decades ago.

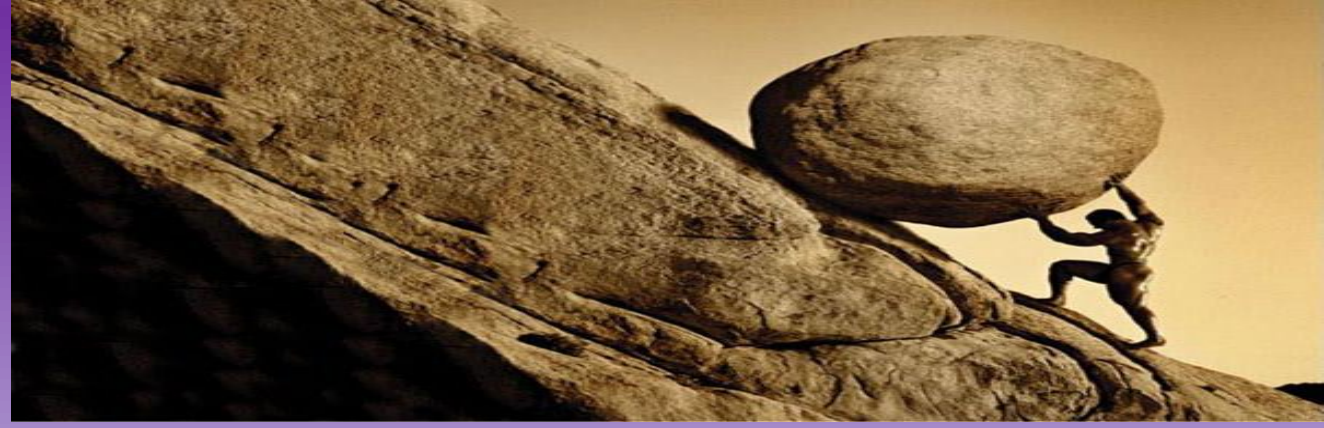
- **A child from a disadvantaged background is still far less likely do well in their GCSEs at 16.**
- **Children living in deprived areas are much more likely to be obese than those living in affluent areas.**
- **Children from disadvantaged backgrounds are more likely to suffer accidental injuries at home.**
- **Children living in the most deprived areas are much less likely to have access to green space and places to play.**



Overall the inequality that existed 50 years ago still persists today, and in some respects has become worse.

The fact that the poverty and inequality experienced by our children remains just as prevalent today as it did nearly 50 years ago must not be ignored…there is a real risk of sleepwalking into a world where inequality and disadvantage are so deeply entrenched that our children grow up in a state of social apartheid.

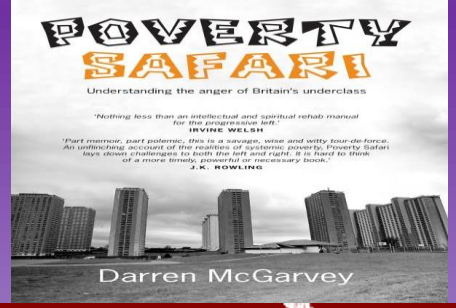
Enduring Challenges



'Despite the improving picture of childhood health, there remains significant inequality in children's experience of the wider social determinants of health, resulting in long term and enduring health inequalities… **health is influenced by the distribution of income, wealth and power within a society which are in turn influenced by the social, economic and political structures…**

This means that **children living in poverty are most at risk of the negative impact of the wider determinants of health. One in four (260,000) of Scotland's children are officially recognised as living in poverty** – defined as living in a household with less than 60% of median household income' **http://www.healthscotland.scot/population-groups/children**

CHILD POVERTY SAFARI



Constituency	% of children in poverty 2017 (after housing costs)
1. Bethnal Green and Bow	54.18%
2. Birmingham, Ladywood	53.06%
3. Poplar and Limehouse	52.75%
4. Birmingham, Hodge Hill	51.46%
5. Manchester, Gorton	47.97%
6. Birmingham, Hall Green	47.82%
7. Manchester Central	47.52%
8. Bradford West	47.26%
9. Bradford East	46.73%
10. Oldham West and Royton	45.58%
11. Edmonton	45.39%
12. Glasgow Central	45.06%

'End Child Poverty coalition calls for an end to the freeze on children's benefits as new figures released today show that there are some constituencies in the UK today where more than half of children are growing up in poverty. The figures also show that some of the most deprived areas of the UK have seen the biggest increases in child poverty since the coalition's last local child poverty figures for December 2015.The coalition is also concerned that the impact of poverty may be exacerbated by a poverty premium… low income families can face paying as much as £1700 per year more than better off families, to buy the same essential goods and services. A major contributor to this is the high cost of credit for low income families, and the coalition wants to see the Government address this by providing better access to interest free credit'

Poverty and children's health: views from the frontline

- '[We] see parents in A&E who are limiting their eating to care for their children. **Children are worried, scared and upset**.'
- 'Many of our [patients] are from **low income families who rely on food banks**'
- 'I see **many disabled children who are living in inadequate housing** which causes significant stress to families, back problems through having to lift children, etc.'
- '**Single mother evicted from rented property** given accommodation in a Travelodge in another town. The child had multiple allergies. Could not afford decent meals.'

- **Families on lower incomes are not able to provide the opportunities which may directly impact health** – for example continuous glucose monitoring devices; healthy food; sports and other activities'
- 'Issues that could and should have been managed by routine universal services (such as parenting support) have not been **due to service cuts, and therefore we see families when they have reached crisis point**.'
- '**Financial worries** are a huge concern for many of our families and have **an impact on parents' mental health and their ability to cope** with challenging circumstances'

Key Findings

This report, produced by Kellogg's, explores the impact of hunger in the classroom, its effects on learning and the long-term implications for our children. Our findings are based on research done by YouGov, conducted with more than 700 teachers in England and Wales.

One in seven children goes to school without breakfast[1] and this is on the increase, significantly impacting on the learning ability of children who lack the basic fuel required to concentrate and learn.

The report demonstrates:

1. **2.4 pupils** in every class in England and Wales will arrive at school hungry at least once a week.[2]
2. Around **8,370 schools** in England have children arriving hungry or thirsty every morning.[3]
3. If a child arrives at school hungry, teachers say they lose **one hour of learning time a day.**
4. If a child arrived at school hungry once a week they would lose **8.4 weeks of learning time (70 per cent of a term) over the whole of their primary school life.**
5. **28 per cent** of teachers have witnessed an increase in children arriving at school hungry.
6. **31 per cent** of teachers say they have to spend a disproportionately higher amount of teaching time with children who arrive at school hungry, than with those who don't.
7. The grip of hunger could potentially cost the English economy at least **£5.2million[4] a year** through teachers losing teaching hours to cope with the needs of hungry children.

If a child arrives at school hungry once a week they will lose 70 per cent of a term over the whole of their primary school education

VICTORIAN VALUES

School meals

Council plans free school meals all year to tackle 'holiday hunger'

North Lanarkshire proposal comes as teachers report seeing more malnourished pupils

Libby Brooks
Scotland correspondent
Fri 16 Feb 2018
10.45 GMT

This article is over 2 months old

2408

▲ The plan would cost about £500,000 a year. Photograph: Suzanne Plunkett/Reuters

You are here: Home: Council and community: News: News: Trial of 'Club 365' to take place in Coatbridge over the Spring break

Trial of 'Club 365' to take place in Coatbridge over the Spring break

North Lanarkshire Council is providing free meals and activities at weekends and holidays for P1-S3 pupils who are entitled to free school meals

A pilot project will take place at four venues in Coatbridge from Friday 30 March to Sunday 15 April (public holidays included).

There will also be multi-sports games and fun activities on offer each day.

Children can come along to any one of these venues (there's no need to pre-book) between 11.30am to 2.30pm (lunch will be served from 12.45pm).

- **Old Townhead Community Centre**, Townhead Road, Coatbridge, ML5 2HT

Contact us

Club 365

Education, Youth and Communities
Municipal Building
Kildonan Street
Coatbridge
ML5 3BT
Send a message to Club 365
Phone: 01236 812314
More details

'I NOTED SUCH CASES OF CHILDREN WITHOUT AN OUNCE OF SUPERFLUOUS FLESH UPON THEM, WITH SKIN HARSH AND ROUGH…I FEAR IT IS FROM THIS CLASS THAT THE RANKS OF PILFERERS AND SNEAK THIEVES COME, AND THEIR CLEVERNESS IS NOT OF ANY REAL INTELLECTUAL VALUE'

DR ARKLE REPORTING TO THE POOR LAW COMMISSION IN 1908

Anne Mullin Parenting in Scotland 2018

21ST CENTURY SOLUTIONS

Good Childhood Report 2017

However, there is an increasing gap emerging between the scale of the need and the funding available for local authorities to help children and families deal with these problems. The Government must urgently review the funding available for local authority children's services in order to equip them to adequately address the scale of demand.

https://www.childrenssociety.org.uk/the-good-childhood-report-2017

In keeping with our expectations, we found some types of disadvantage to be more widespread than others. Using Office for National Statistics (ONS) mid-year population estimates for 2016, we estimate that approximately 2.2 million 10 to 17 year olds across the UK are worried about crime in their local area. There are also 2.1 million living in households that are struggling with their bills. The full list of disadvantages explored is included in Table 1.

Table 1: Population estimates for various types of disadvantage

Type of disadvantage	% of children	Estimated population of 10 to 17 year olds experiencing disadvantage in the UK[4]
Parent-child relationships		
Emotional neglect: Child has experienced emotional neglect	4.1%	200,000
Supervisory neglect: Child has experienced supervisory neglect	4.5%	250,000
Young carer: Child is a young carer	9.3%	500,000
Family/household factors		
Domestic violence: (Responding) parent has experienced domestic violence	13.3%	750,000
Alcohol: (Responding) parent has had problematic alcohol use	12.4%	700,000
Parental mental health: (Responding) parent has had a mental health problem	28.4%	1,650,000
Prison: Someone in the household has been in prison	3.9%	200,000
Parental illness/disability: (Any) parent/ carer has had a long-standing illness or disability	22.2%	1,250,000
Child illness/disability: (Any) child has had a long-standing illness or disability	13.1%	750,000
Bereavement: Someone in the household has died	7.4%	400,000
Residential transience: Family has moved house multiple times	20.5%	1,150,000
Forced move: Family has experienced a forced house move	13.7%	750,000
Maternal education: Mother left school without qualifications	5.2%	300,000
Paternal education: Father left school without qualifications	6.3%	350,000

PASS IT ON

HISTORICAL AND GENERATIONAL TRAUMA - EPIGENETIC CONSEQUENCES OF TOXIC STRESS

TOXIC STRESS CAUSED BY ACES CAN ALTER HOW OUR DNA FUNCTIONS.

THAT CAN BE PASSED ON FROM GENERATION TO GENERATION

NOT ONLY ASKING: "WHAT HAPPENED TO YOU?", ALSO ASKING"WHAT HAPPENED TO YOUR PARENTS?" TO YOUR GRANDPARENTS?

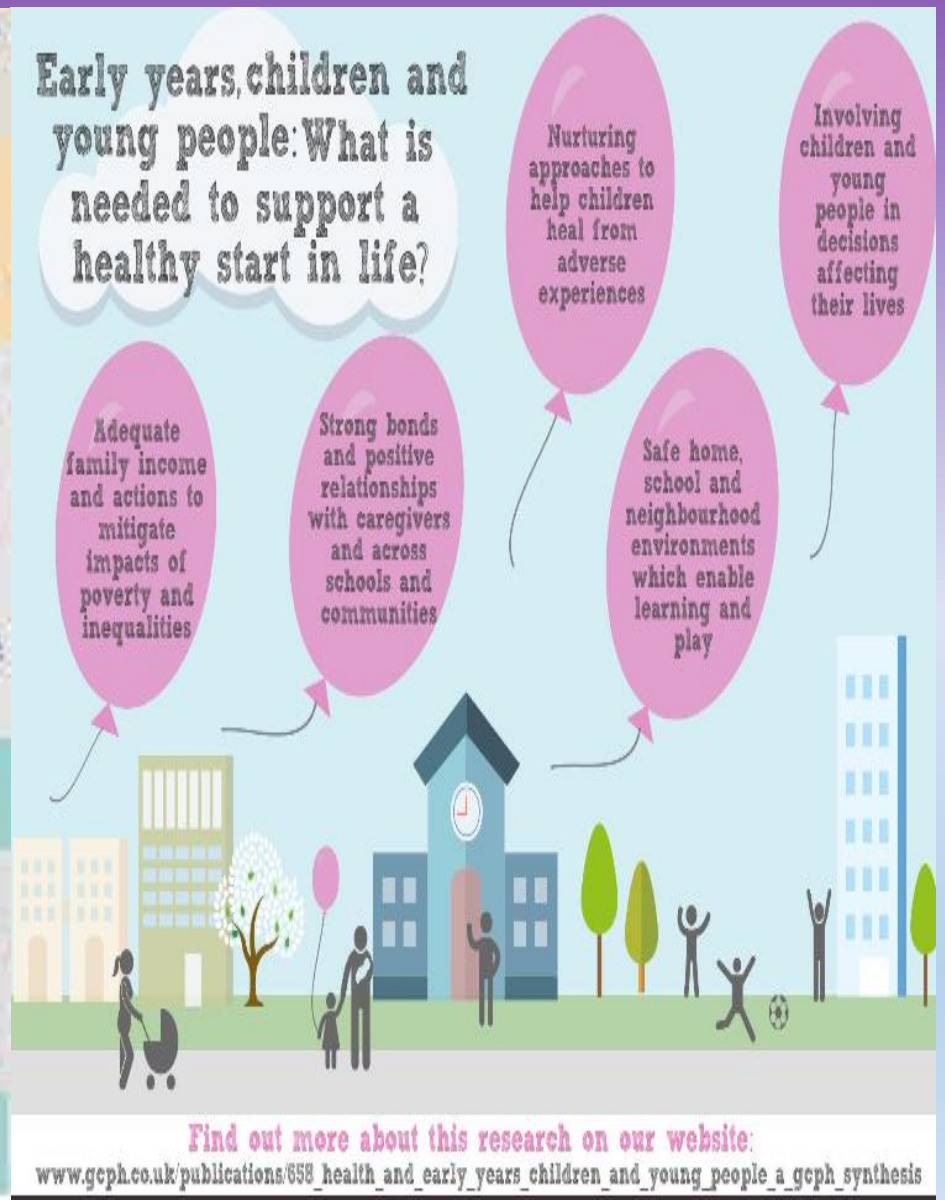
TO YOUR GREAT-GRANDPARENTS? TO YOUR TRIBE, ETHNIC GROUP, ETC.?

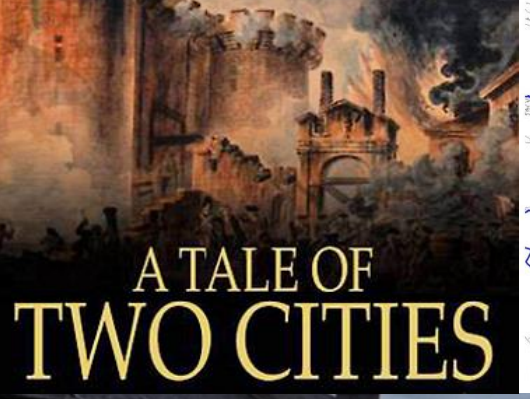
Reproduced with the permission of Warren Larkin

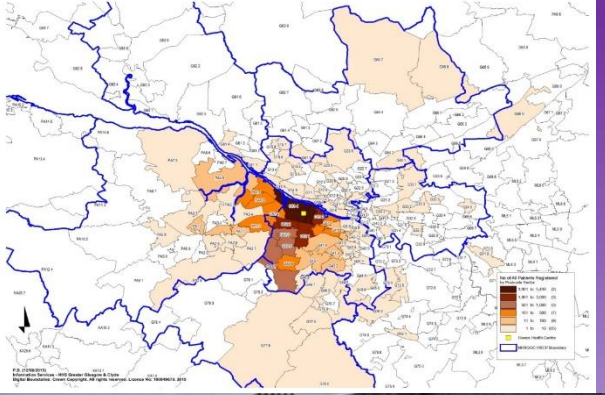
CREATING HEALTH-PROMOTING ENVIRONMENTS FOR ADOLESCENTS WILL ULTIMATELY REQUIRE ENGAGEMENT WELL BEYOND THE HEALTH SECTOR, WITH EDUCATION, LOCAL GOVERNMENT, INDUSTRY, RELIGIOUS LEADERS, CIVIL SOCIETY AND YOUNG PEOPLE THEMSELVES ALL ESSENTIAL ACTORS. IN A WORLD OF COMPETING POLICY PRIORITIES, THERE IS NO DOUBT THAT PROVIDING THE RESOURCES FOR HEALTHY ADOLESCENT GROWTH, EDUCATION AND EMOTIONAL DEVELOPMENT WILL YIELD LARGE BENEFITS FOR CURRENT AND FUTURE GENERATIONS.

Adolescence and the next generation doi:10.1038/nature25759

We Know the Answers!

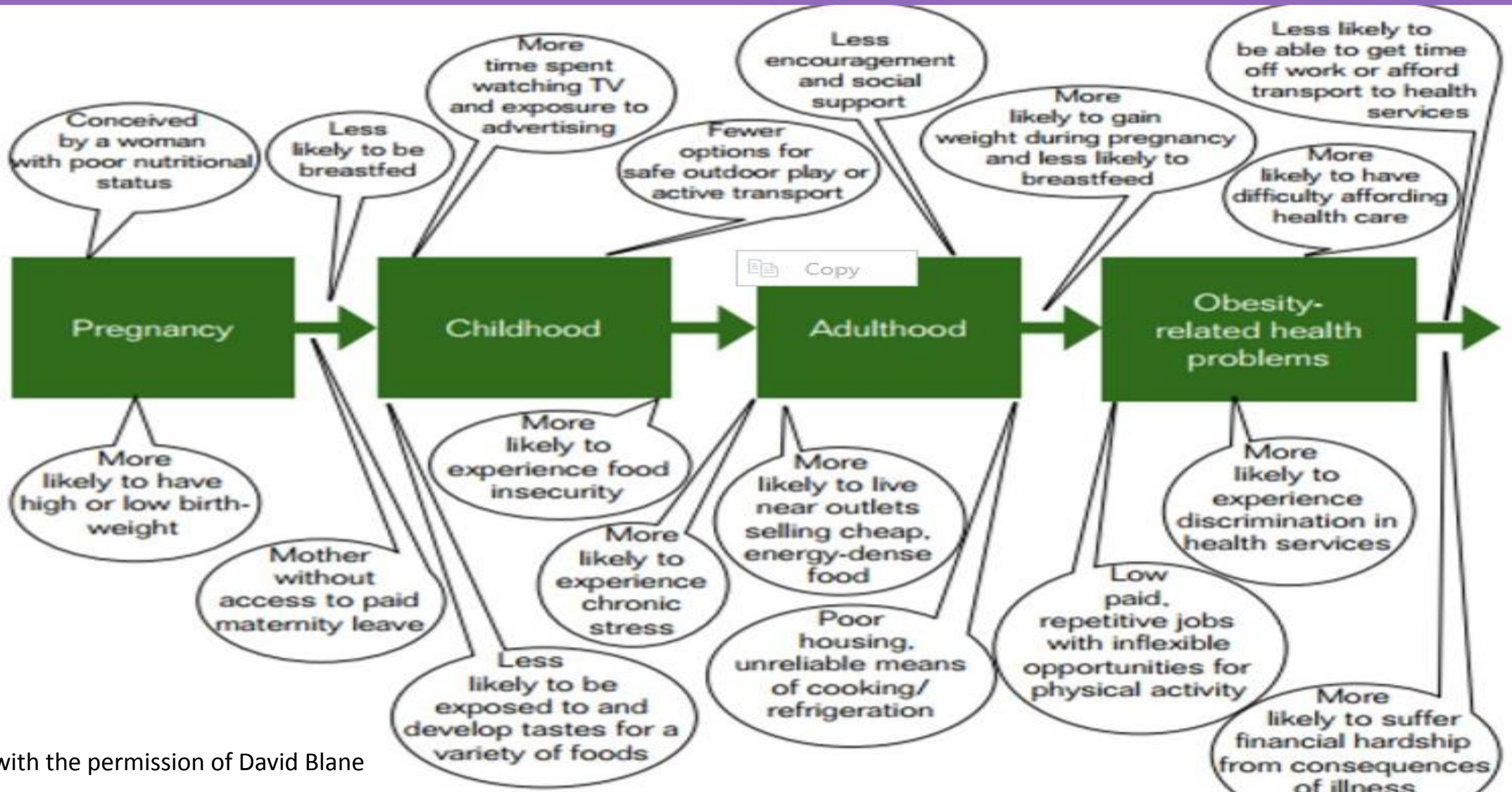






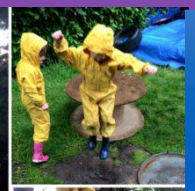
Measure	Govan/ Linthouse	WhiteCraigs
Male Life Expectancy	67	85
Female Life Expectancy	73	94
Patients hospitalised with coronary heart disease	570	35
Early deaths from CHD (<75)	95	35
Patients hospitalised with asthma	94	44
Patients with emergency hospitalisations	11880	5621
Patients (65+) with multiple emergency hospitalisations	8913	3979
Patients with a psychiatric hospitalisation	630	95
Deaths from suicide	36	11
Teenage pregnancies	81	17
Mothers smoking during pregnancy	32%	3.4%
Immunisation uptake at 24 months - 5 in 1	97.6%	97.1%
Immunisation uptake at 24 months - MMR	97%	93%
Children Living in Poverty http://www.scotpho.org.uk	38%	3%

THE GENEALOGY OF THE OBESITY CRISIS



Reproduced with the permission of David Blane

RISKY PLAY – ARE WE READY TO TAKE THAT LEAP?







TYPES OF RISKY PLAY	
Category	**Examples**
Great heights	Climbing, jumping from still or flexible surfaces, balancing on high objects, swinging at great heights
High speed	Swinging, sledding, running, cycling, skating, skiing
Dangerous tools	Using knives, saws, axes and ropes
Dangerous elements	Playing around cliffs, deep or icy water, or fire pits
Rough-and-tumble	Wrestling, fencing with sticks, play fighting
Getting lost	Exploring alone, playing alone in unfamiliar environments

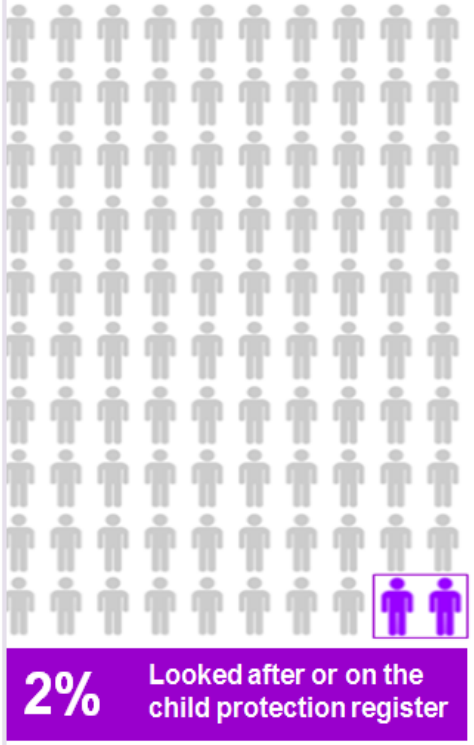
'injuries are an inevitable side effect of physical activity, which is necessary for a healthy and active lifestyle…children in an experimental group exposed to a 14-week risky play intervention **improved their risk detection and competence, increased self-esteem and decreased conflict sensitivity,** The vast majority of risky outdoor play-related injury incidents result in minor injuries requiring minimal or no medical treatment

Risk minimised by;

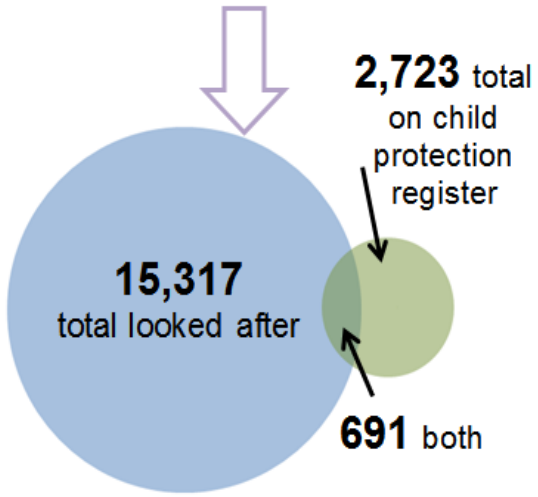
- **Adult Supervision**
- **Playground Safety Standards**

Int. J. Environ. Res. Public Health 2015, 12, 6423-6454doi:10.3390/ijerph120606423

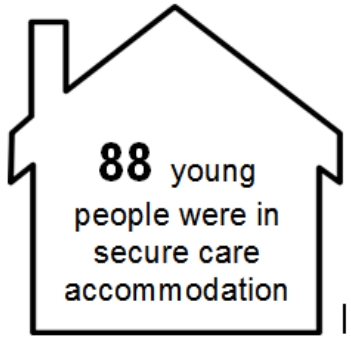
Children's Social Work Statistics Scotland, 2015-16



As at 31 July 2016, 17,349 children in Scotland were looked after or on the child protection register



2% Looked after or on the child protection register



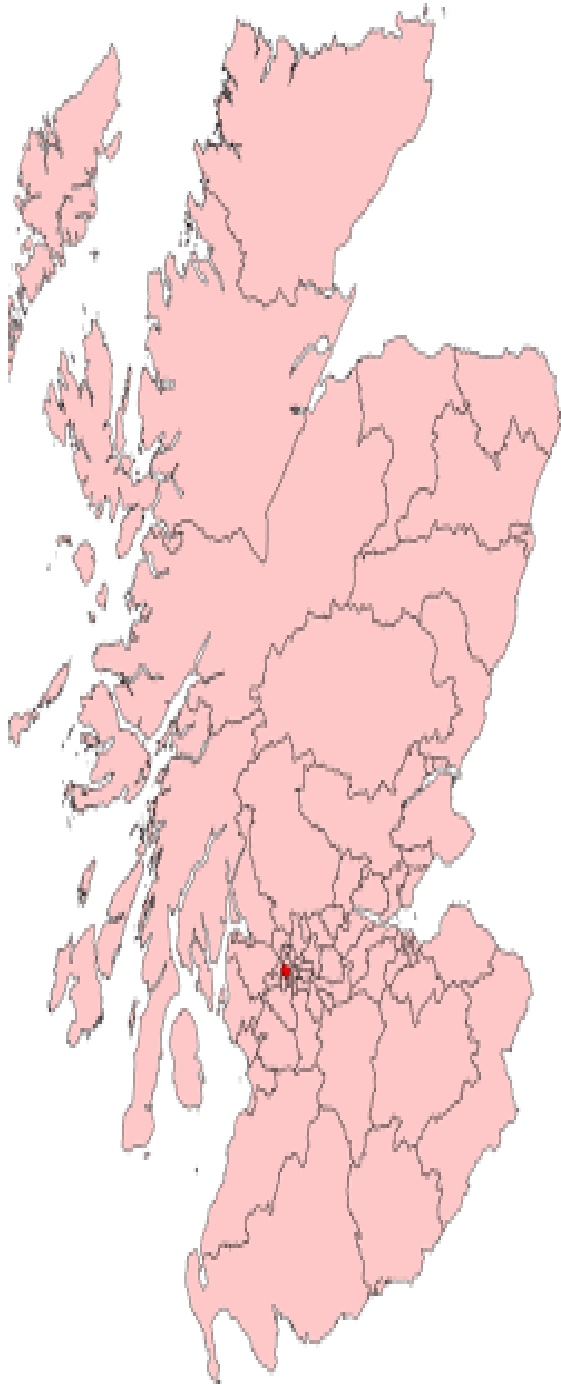
Comparisons with 2014-15:

- **1%** decrease in number of children looked after
- **1%** decrease in number of children on child protection register
- **3** more residents, on average, during the year in secure care accommodation

A Sense of Proportion

SHIP Practice Patients <18Y	ALL	SHIP	Non-SHIP	SHIP (as %)
Female	1209	129	1080	10.7%
Male	1322	153	1169	11.6%
Total	2531	282	2249	11.2%

	GSL SW CP Stats Children<18Y
Looked after away from home	N=81
Looked after at home	N=63
Placed on CP Register	N=15



Anne Mullin November 2017

12/10/16 (SOUTH CHP)	LOOKED AFTER & ACCOMODATED	LOOKED AFTER IN HOME SETTING	ON CHILD PROTECTION REGISTER
Male	190	277	54
Female	207	255	50
Total	397	532	111 (7 UNBORN) (2723)
AGEBAND			
0-4 years	69	57	47(INCL. UNBORN)
5-9years	95	151	34
10-12 years	63	132	15
13-15 years	89	124	4
>16 years	91	68	1
TYPE OF PLACEMENT			Dom. Abuse 31 Neglect 29 Emotion. Abuse 24 Phys. Abuse 17 Sex Abuse 15 Parental MH 3 Non-eng. Family 2 Alcohol Issues 2 Drug Problems 2
Foster care	341		
Children's Unit	41		
Other	15		
With Parents		145	
Kinship		387	

Scotland's Population Children & Young People 2016

0-15 yrs 0.92 million ;16-24 yrs 0.61 million

SUPPORTING PARENTS & CHILDREN- WHERE SHOULD WE BE LOOKING ?
WHAT LIES BENEATH

- RESISTANT PARENTS - HOSTILITY – WORKERS BACK OFF AVOIDANT PARENTS - DNAS FOR MEDICAL OR SCHOOL APPOINTMENTS CHAOTIC/UNSTABLE PARENT
- APPARENT COMPLIANCE - NOT IN FOR HOME VISIT, BUT COME TO OFFICE LATER – DIRT ETC COVERING BRUISES, CHILD NOT SEEN ALONE - COLLUSION BY WORKERS
- CHILD NOT SEEN - NON SCHOOL ATTENDER
- CORE FAMILIES ON HEALTH VISITOR CASELOADS – NO REGULAR CONTACT
- CULTURAL – DIFFERENT VIEWS ABOUT CHILD REARING
- TRAFFICKING
- ORGANISATIONAL -BIG CASELOADS - POOR RECORDING -INEXPERIENCED WORKERS, LACKING CONFIDENCE -WORKER THRESHOLDS - LINKING TOGETHER INFORMATION E.G. INVOLVING THIRD SECTOR

= INVERSE CARE LAW (HEALTH)

= INVERSE INTERVENTION LAW , START AGAIN SYNDROME (SOCIAL SERVICES)

Addressing childhood adversity and trauma

WHAT IS ADVERSITY?

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence

It can be a single event, or prolonged threats to, and breaches of, a young person's safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations are children and young people's attempts to:

- Survive in their immediate environment
- Find ways of mitigating or tolerating the adversity by using available resources
- Establish a sense of safety or control
- Make sense of the experiences they have had

NEW KID ON THE BLOCK

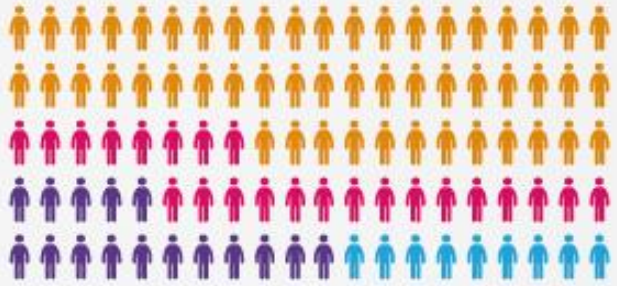
HOW COMMON ARE ACES?

Around half of all adults

living in England have experienced at least one form of adversity in their childhood or adolescence

Of all children and young people:

- 52% experienced 0 ACEs
- 23% experienced 1 ACE
- 16% experienced 2-3 ACEs
- 9% experienced 4+ ACEs



WHAT KINDS OF EXPERIENCES ARE ADVERSE?

Forms of ACEs include:

Maltreatment
i.e. abuse or neglect

Violence & coercion
i.e. domestic abuse, gang membership, being a victim of crime

Adjustment
i.e. migration, asylum or ending relationships

Prejudice
i.e. LGBT+ prejudice, sexism, racism or disablism

Household or family adversity
i.e. substances misuse, intergenerational trauma destitution, or deprivation

Inhumane treatment
i.e. torture, forced imprisonment or institutionalisation

Adult responsibilities
i.e. being a young carer or involvement in child labour

Bereavement & survivorship
i.e.traumatic deaths, surviving an illness or accident

HOW DOES IT IMPACT THE LIVES OF YOUNG PEOPLE?

ACEs impact a child's development, their relationships with others, and increase the risk of engaging in health-harming behaviours, and experiencing poorer mental and physical health outcomes in adulthood.

Compared with people with no ACEs, those with 4+ ACEs are:

- **2x** more likely to binge drink and have a poor diet
- **3x** more likely to be a current smoker
- **4x** more likely to have low levels of mental wellbeing & life satisfaction
- **5x** more likely to have had underage sex
- **6x** more likely to have an unplanned teenage pregnancy
- **7x** more likely to have been involved in violence
- **11x** more likely to have used illicit drugs
- **11x** more likely to have been incarcerated

WHAT PROTECTS YOUNG PEOPLE FROM ACES?

Not all young people who face childhood adversity or trauma go on to develop a mental health problem.

There are personal, structural and environmental factors that can protect against adverse outcomes, as shown in the protection wheel opposite.

WHAT CAN WE DO ABOUT IT?

Commissioners can address childhood adversity and trauma by:

1. Making childhood adversity and trauma a local commissioning priority
2. Creating a common identification and enquiry framework for identifying need
3. Investing in adversity and trauma-informed models of care

https://youngminds.org.uk/media/2142/ym-addressing-adversity-book-web.pdf

Protective factors	Risk Factors		
	Belonging to a vulnerable group:	Social and cultural factors:	Interpersonal and individual risk factors:
• Positive temperament • Intellectual ability • Positive and supportive family environment • Social support system • Caring relationship with at least one adult • In education, employment or training	• Looked-after children • School non-attenders • Having mental health problems • Drug misuse by parents • Abuse within the family • Homelessness • Young offenders • Young sex workers	• High levels of neighbourhood poverty and decay • High levels of neighbourhood crime • Easy drug availability • Widespread social acceptance of alcohol and drug use • Lack of knowledge and perspective of drug-related risks	• Physiology and psychology factors • Family dysfunction • Behavioural difficulties • Academic problems • Association with peers who use alcohol and drugs • Early onset of tobacco smoking • Early onset of alcohol and drug use

GENERAL PRACTICE BRICOLAGE.
SUPPORTIVE FAMILY PRACTICE –IT'S AN ARTFUL SCIENCE

The essential ingredients for general practice to make a difference.

CONSULTATIONS, CARING, CONTINUITY,

COVERAGE, CAPACITY, COMMUNITY, COORDINATION,

CREATIVITY, COMMITMENT,

COLLEGIALITY, CONSISTENCY AND CAMPAIGNING (Graham Watt)

What Patients Want;

- **CARING AND COMPASSIONATE STAFF AND SERVICES**
- **CLEAR, EFFECTIVE COMMUNICATION AND EXPLANATION ABOUT CONDITIONS AND TREATMENT**
- **EFFECTIVE COLLABORATION BETWEEN CLINICIANS, PATIENTS AND OTHERS**
- **A CLEAN AND SAFE ENVIRONMENT**
- **CONTINUITY OF CARE**
- **CLINICAL EXCELLENCE.**

NHS Healthcare Quality Strategy

It's Not All About Ticking a Box For Clicky Hips and Heart Murmers!

GPs have a minimal role in child health surveillance in Scotland since 2006
-a single assessment at 6-8 weeks focussed on physical examination.

Coverage of the 10 day review is high (99%), but it progressively declines for reviews at older ages (86% for the 39–42 month review).

Coverage is lower in children living in the most deprived areas for all reviews, and the discrepancy progressively increases for reviews at older ages (78% and 92% coverage for the 39–42 month review in most and least deprived groups).

The inverse care law continues to operate in relation to 'universal' child health reviews. Equitable uptake of reviews is important to ensure maximum likely impact on inequalities in children's outcomes
Wood et al http://dx.doi.org/10.1136/bmjopen-2011-000759

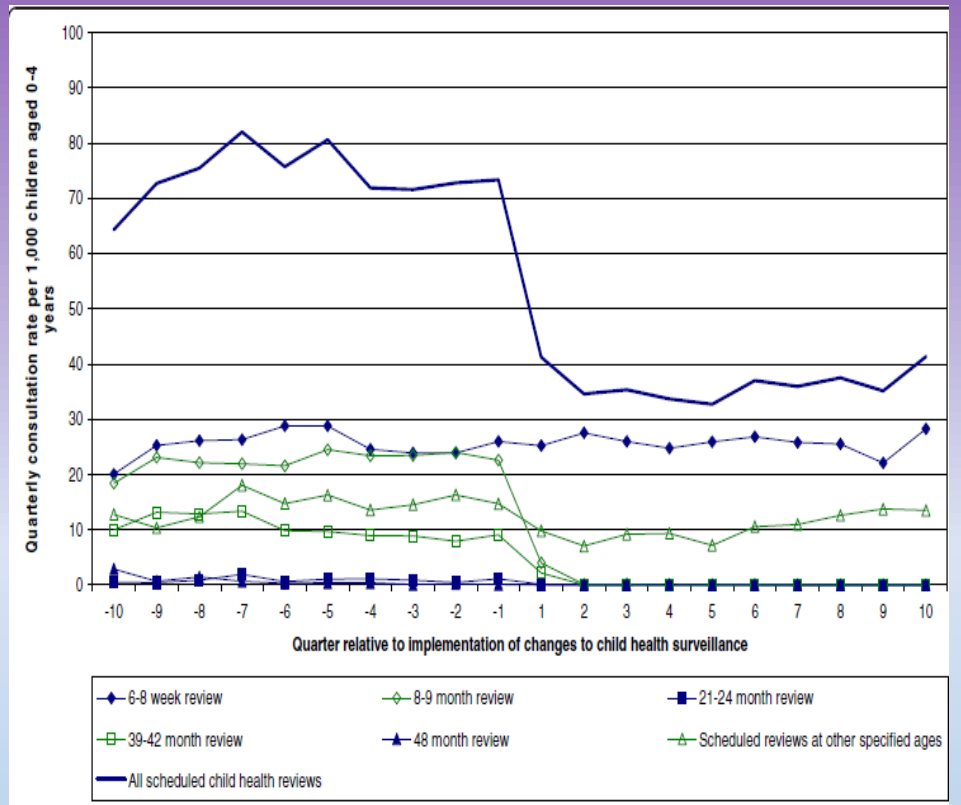


Figure 1 GP consultations with children aged 0–4 years for child health reviews, rates before and after implementation of changes to the child health surveillance system.

KEEP THE BABY IN THE BATHWATER

Prior to the changes to the CHS system, GPs often contributed to CHS reviews at 6–8 weeks and 8–9 and 39–42 months.
Following the changes, **GP provision of the 6–8 week review continued but other reviews essentially ceased**. Few additional consultations with pre-school children are recorded as involving other aspects of preventive care, and the changes to CHS have had no impact on this.
In the 2½ years before and after the changes, consultations recorded as involving any form of preventive care accounted for 11% and 7.5% respectively of all consultations with children aged 0–4 years, with the decline due to reductions in CHS reviews.

Effective preventive care through the early years can help children secure good health and developmental outcomes. GPs are well placed to contribute to the provision of such care.
Consultations focused on preventive care form a small minority of GPs' contacts with pre-school children, however, particularly since the reduction in the number of CHS reviews.

Wood and Wilson BMC Family Practice 2012, 13:73 http://www.biomedcentral.com/1471-2296/13/73

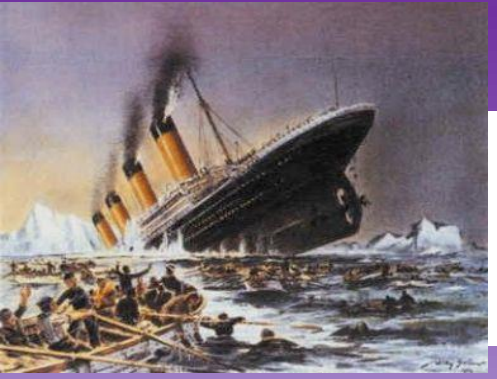
WHAT DOES THE 'TROUBLED FAMILY' LOOK LIKE?

David is 14 months old. His 18 year old mum Sarah has had anxiety problems since her older brother hanged himself four years ago. She started college but left when she fell pregnant shortly afterwards. Sarah does not get on well with her mother, whom she accuses of drinking and "always shouting" since her brother died. Her mum says she is "mental" and a "teenage brat". Sarah relies heavily on her own gran Margaret. Aged 50 she has moderately severe COPD (emphysema) and continues to smoke. Margaret has had several chest infections recently and is struggling to cope with Sarah's often strange behaviour and with a lively toddler for whom she is the main caregiver.

For David the next two years, as he learns to walk, talk and interact, will have a huge effect on the rest of his life. Early years interventions such as parenting classes may be important, but on their own will fail to change his life opportunities. He will need supportive neighbours, a good nursery and adequate family income, but also optimal COPD nurse reviews, responsive alcohol and mental health services, good communication with social work, persistent contraceptive advice and smoking cessation support, to name a few. At the hub of these lies the primary care team, offering unconditional care and the possibility of trusted relationships over the span of David's life (Deep End Report 23).

Shining a light on what can be learned from new care models to change in the NHS Starling, The Health Foundation

1. Start by focusing on a specific population.
- 2. Involve primary care from the start.
- 3. Go where the energy is.
- 4. Spend time developing shared understanding of challenges.
- 5. Work through and thoroughly test assumptions about how activities will achieve results.
- 6. Find ways to learn from others and assess suitability of interventions.
- 7. Set up an 'engine room' for change.
- 8. Distribute decision-making roles.
- 9. Invest in workforce development at all levels.
- 10. Test, evaluate and adapt for continuous improvement.



GOVAN SHIP Getting Us From H1-H3

HORIZON 1 SINKING IN THE DEEP END

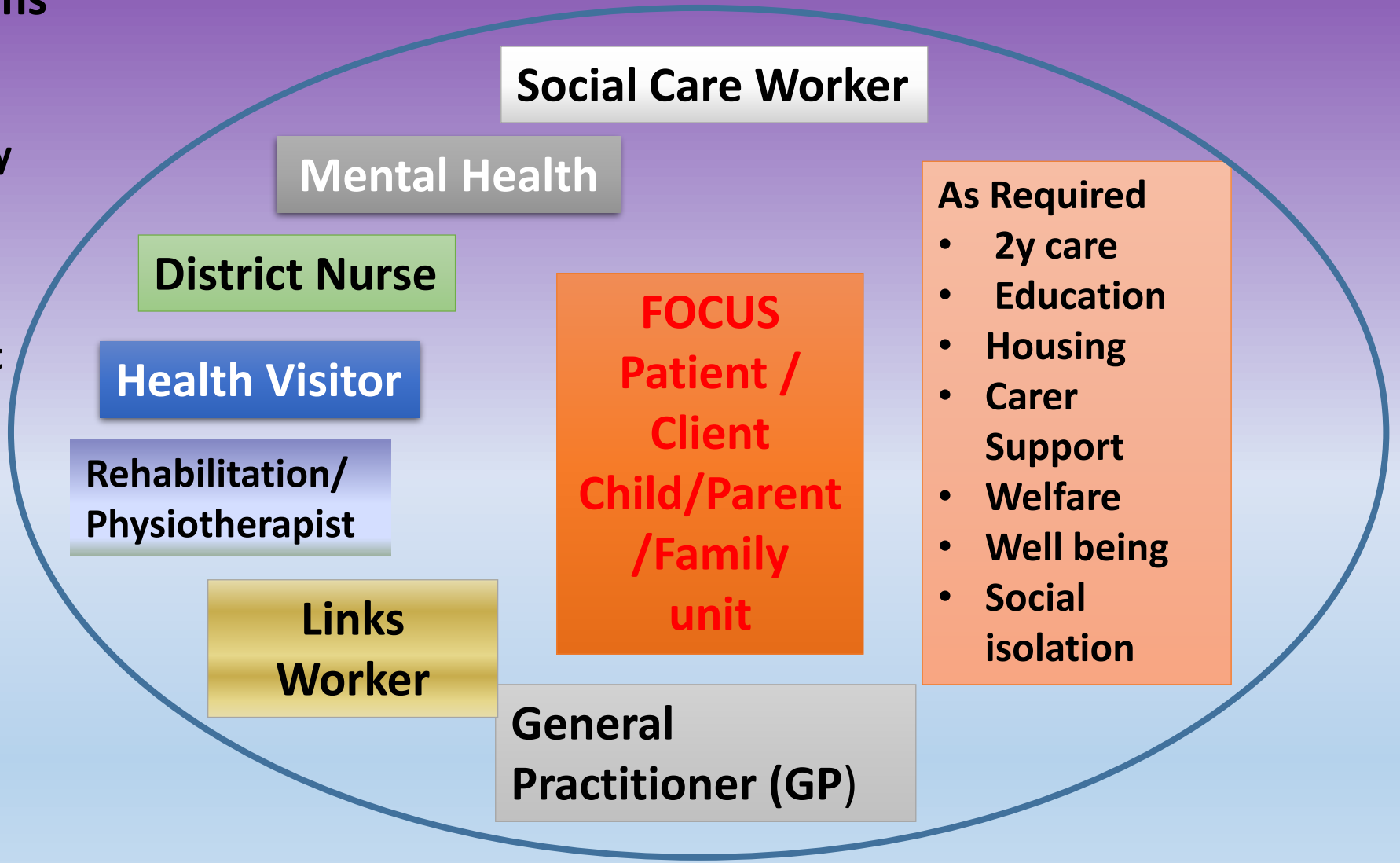
- PRE-ESTABLISHED TEAM WORKING BUT NO STRATEGIC SUPPORT
- COLLECTIVE MEMORY OF WORKING WITH ATTACHED SOCIAL WORKER- A POSITIVE EXPERIENCE. LOSS OF ORGANISATIONAL MEMORY
- CLUNKY COMMUNICATION SYSTEMS - AN ONGOING FRUSTRATION
- FRAGMENTED DATA SYSTEMS
- GP CONTRACT - MINIMISES MATERNITY, PAEDIATRIC AND FAMILY HEALTH CARE
- NO SPECIFIC ROLE FOR GPS IN CARE OF VULNERABLE CHILDREN & FAMILIES DESPITE BEING THE 'HUB' AND POINT OF CONTACT FOR OTHER SERVICES / OUTSIDE AGENCIES
- VULNERABLE ADULTS OFTEN DON'T REACH THRESHOLDS OF SERVICE PROVISION.BOUNDARIES TO SERVICE PROVISION ARE BARRIERS TO ACCESS TO SERVICE
- VERY LITTLE RESEARCH TO ARGUE OUR CASE. GPS DON'T WRITE THINGS DOWN, DIFFICULT TO QUANTIFY 'NON EVENTS'
- EXPERIENCE DOESN'T SEEM TO COUNT

HORIZON 3 SAILING ON CALM WATERS

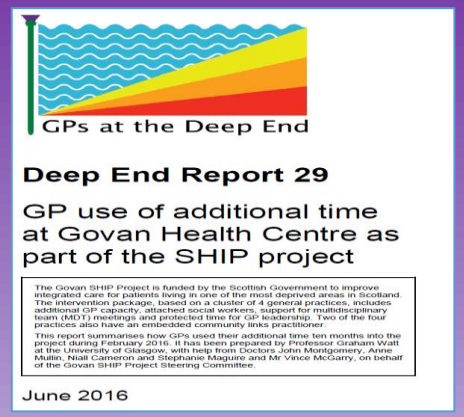
- PROTECTED TIME - CASE PLANNING
- PROFESSIONAL RELATIONSHIPS - FACE-TO FACE DISCUSSIONS- BLURRING THE BOUNDARIES – ALL WORKING AS GENERALISTS,
- INFRASTRUCTURE- E.G. MDT MEETINGS ,JSTs, WHOLE SYSTEMS APPROACH, 1Y & 2Y CARE INTERFACE, STEERING GROUP
- MULTIMORBIDITY DATABASE
- DOCUMENTATION - MINUTED MEETINGS, DIARIES ADMIN SUPPORT
- PATIENT ENGAGEMENT
- RESEARCH THAT FITS WORKING PRACTICES (E.G. EVALUATION REPORT)
- BIGGER PICTURE - LINKS WORKERS, MENTAL HEALTH, EDUCATION, 3RS SECTOR MANAGEMENT (UNDERSTANDING BUDGETARY CONSTRAINTS AND PLANNING NETWORKS)
- NORMALISING THE PROJECT WORK THROUGH CONNECTIVITY, EMBEDDED KNOWLEDGE, KNOWLEDGE EXCHANGE – AN ECOLOGY OF LEARNING

Putting It All Together – SHIP MDT

- **Workstreams**
- **Children & Families**
- **Frail & Elderly**
- **Unscheduled Care**
- **Information Management**
- **Other**



Won't Somebody Please Think of the Children?


GPs at the Deep End

Deep End Report 29

GP use of additional time at Govan Health Centre as part of the SHIP project

The Govan SHIP Project is funded by the Scottish Government to improve integrated care for patients living in one of the most deprived areas in Scotland. The intervention package, based on a cluster of 4 general practices, includes additional GP capacity, attached social workers, support for multidisciplinary team (MDT) meetings and protected time for GP leadership. Two of the four practices also have an embedded community links practitioner.

This report summarises how GPs used their additional time ten months into the project during February 2016. It has been prepared by Professor Graham Watt at the University of Glasgow, with help from Doctors John Montgomery, Anne Mullin, Niall Cameron and Stephanie Maguire and Mr Vince McGarry, on behalf of the Govan SHIP Project Steering Committee.

June 2016

Case 1 **'Extended surgery consultation with school age child and mother due to behavioural problems at school stemming from Autistic Spectrum Disorder. Outcome: discussed support structures available through health, education and third sectors. Information regarding diagnosis and impact on family discussed at length. Management strategies discussed and agreed for both individuals with goal setting, etc.'**

Case 2 **'Child < 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness; Outcome: linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.'**

That Jigsaw Thing

- *EVERY CHILD , EVERY CHANCE*
- *GIRFEC*
- *EARLY YEARS FRAMEWORK*
- *REFRESHED FRAMEWORK FOR MATERNITY CARE SCOTLAND*
- *NATIONAL PARENTING STRATEGY*
- *EARLY YEARS COLLABORATIVE + RAISING ATTAINEMENT FOR ALL=CYPIC*
- *BOOK BUG*
- *BABY BOXES*
- *NAMED PERSON*
- *EARLY LEARNING AND CHILDCARE*
- *CHILDREN AND YOUNG PEOPLE (SCOTLAND) ACT 2014*

THE WELLBEING OF PEOPLE AND COMMUNITIES IS CORE TO THE AIMS AND SUCCESS OF COMMUNITY

A STRONG AND THRIVING GENERAL PRACTICE IS CRITICAL TO SUSTAINING HIGH QUALITY UNIVERSAL HEALTHCARE AND REALISING SCOTLAND'S AMBITION TO IMPROVE OUR POPULATION'S HEALTH AND REDUCE HEALTH INEQUALITIES.

EQUALITIES AND SOCIO ECONOMIC IMPACTS ARE UNDER CONSIDERATION

GPS WILL BE MORE INVOLVED IN INFLUENCING THE WIDER SYSTEM TO IMPROVE LOCAL POPULATION HEALTH IN THEIR COMMUNITIES (*Primary Care Improvement Plan)*

WORDS AND DEEDS

REPORT 3 The GP Role In Working With Vulnerable Families (Jan 2010)
REPORT 6 Patient Encounters In Very Deprived Areas: What Can Be Achieved? (May 2010)
REPORT 8 Social Prescribing (Sep 2010)
REPORT 12 Working Together For Vulnerable Children And Families (Sep 2010)
REPORT 18 Integrated Care (Jul 2012)
REPORT 20 What Can NHS Scotland Do To Prevent/Reduce Health Inequalities? (Apr 2013)
REPORT 23 The Contribution Of General Practice To Improving The Health Of Vulnerable Children And Families (Jun 2014)
REPORT 25 Strengthening Primary Care Partnership Responses To The Welfare Reforms (Nov 2014)
REPORT 26 Generalist And Specialist Views Of Mental Health Issues In Very Deprived Areas (Dec 2014)
REPORT 29 GP Use Of Additional Time As Part Of The SHIP Project (June 2016)

Safeguarding in general practice has the potential to use core 'family doctor' skills to meet the health needs (in the widest sense of the term) …young people, and their families and doing so in tandem with statutory child protection responses…Models of care that promote continuity of care and **a holistic approach are likely to facilitate effective GP responses to these children and their families.**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4141592/

THANKYOU! ANY QUESTIONS?